DEPAR CENTE	FMENT OF HEALTH RS FOR MI-DICARI	FAND HUMAN SERVICES E&M <u>EDICAID SERVICES 45</u>	u illis	2/16 70th 12/13	_{e71} FÖRM	0: 10/11/2016 MAPPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIERCLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI	E CONSTRUCTION 11 - MAIN BUILDING 01	(X3) DAI	. 0938-0391 TE SURVEY MPLETED
	PROVIDER OR SUPPLIER		82	FRUE JADRIESS, CITY, STATE, Z	10)	/03/2016
(X4) ID FIRE FIX TAG	SHIMMARY ST.	ATEMI, N.I. OI' DELICIENCIES Y MUST DE PRI CEDI-D BY FUIL BC DENTIFYING INFORMATION)	II) PRLITIX TA/3	PROVIDER'S PLAN OF (FACH CORRECTIVE ACT CROSS-REI LIKENCED TO DEFICIENCE	ION SHOULD RE THE APPROPRIATE	(XS) COMPLETION BATE
K 018 SS-D	State of Tennessee Division of Health Lollice of Health Callice Safety from Fire Protection Ass 101-2000. The requirement alias NOT MET as evin NFPA 101 LIFE SAL Doors protecting or required enclosures hazardous areas slas those constructed core wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered strequired to resist the no impediment to the open devices that in pushed or pulled ar provided with a medoor closed. Dutch permitted. Door from made of steel or off with 8.2.3.2.1. Rollic CMS regulations in 19.3.6.3. This STANDARD is Based on observations.	e Survey was conducted by the a Department of Health Licensure and Regulation are Facilities survey on 10/3/16. Tely Survey, NHC of Smithville obstancial compliance with the articipation in at 42 CFR Subpart 483.70(a), we, and the related National ociotion (NFPA) standard. 42 (CFR), Subpart 483.70(a) denced by: FETY CODE STANDARD orridor openings in other than a of vertical openings, exits, or nall be substantial doors, suched of 13/4 inch solid-bonded ble of resisting fire for at least nice between bottom of door is not exceeding 1 inch. Doors smoke compartments are only a passage of smoke. There is ne closing of the doors, Hold elease when the door is a permitted. Doors shall be and suitable for keeping the doors meeting 19.3.6.3.6 are mes shall be labeled and nor materials in compliance or latches are prohibited by all health care facilities.	K 018	*This plan of concention is sub- under State and Federal Law a an admission on the part of Nt Smithwile that the findings cit findings constitute a deficience severity regarding any of the d correctly applied. K018 Maintenance Supervisor devices on doors in Room 206 Office, Activities Office, Parla Case Manager Office, All door Maintenance Supervisor rando on doors throughout the center latching correctly. Maintenance Supervisor will or Assurance Study (QA) on door Maintenance supervisor will in the center for proper latching, to weekly for 3 weeks or until suf- Findings will be reported to the 11/9/16, QA Committee consis Administrator, Director of Nur- Infrantation Manager, Social S Assistant Director of Nursing, a	and does not constitute IC HealthCare and are accurate, that the y, or that the scope and deficiencies cited are i r inspected latching Room 119, MDN at Break Room, and is fatching correctly. and inspected latches on 10/1 1/16. All doors are the second and doors are the second are in a Quality latching. Spect tandom doors in QA will be conducted and will be conducted and Administer on its of Medical Director, and Director of Rehab.	11/3/2016
	DIRECTOR'S OR PROVID	ER/SUPPLIFR REPRESENTATIVES SIGN	IATURE	Administrator		(X8) DATE
14.	PART ARKS			7-1000111) FT4 179	/•	10-1-6

Any deficiency statement onding with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for musting homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For musting homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LORM CMS-2567(02-99) Previous Versions Obsolute

Livent ID: SH5D21

Tigority ID: 7N2101

If continuation sheet Page 1 of 12

PRINTED: 10/11/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MUDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CHA (X2) MULTIME CONSTRUCTION. (X3) DATE SURVLY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A RUII DING 01 - MAIN BUILDING 01 COMPLETED 445116 B WING 10/03/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 825 FISHER AVE P O BOX 549 NHC HEALTHCARE, SMITHVILLE SMITHVILLE, TN 37166 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 10 (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PRLUX (FACITOT FOR NOY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR ESCHOENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATC DIFFICIENCY) Continued From page 1 K 018 drill, the facility failed to maintain the corridor doors. I he finding included: Observation and festing during the fire drift on 10/3/16 at 1:30 PM through 1:40 PM, revealed the following corridor doors not fully latched within the frame in the following locations. a 206 b. 319 c. MPS care office d. Activities e. Partner break Casemanager, National Fire Protection. Association (NFPA) 101, 19.3.6.3 (2000) Edition) Maintenance staff was present when the deficiencies were identified, and acknowledged by the administrator during the exit conference on 10/3/16. K 021 NEPA 101 LIFE SAFETY CODE STANDARD K 021 K021 Peretrations in ICF Fire Door and Reflections 11/3/2016 SS≒D fire doors were repaired on 10/4/16. Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area. Maintenance Supervisor observed all other fire doors enclosure are self-closing and kept in the closed for penetrations on 10/4/16. No other penetrations position, unless held open by as release device found. complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke Maintenance Supervisor will conduct a Quality Assurance Study (QA) on fire door's for penetrations. compartment or critice facility upon activation of: QA will be conducted weekly for 3 weeks or mut-(a) The required manual fire alarm system and substantial compliance. Findings will be reported to (b) Local smoke detectors designed to detect. the QA Committee on 11/3/16. QA Committee smoke passing through the opening or a required consists of Medical Director, Administrator, Director smoke detection system and of Nursing, Health Information Manager, Social (c) The automatic sprinkler system, if installed Services Director, Assistant Director of Narsing, and 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, Director of Robab. 7.2.1.8.2

FORM CMS-2567(02-99) Previous Versions Obsolete

Livord (D: 51/5021

Facility ID: TN2101

If continuation sheet Page 2 of 12

PRINICD: 10/11/2016

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			P	RINICI	: 10/11/2016
		& MEDICAID SERVICES			O		IAPPRÓVIED . 0 938-0391
STATLMENT	T OF OFFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLICE/CEIA IDENTIFICATION NUMBER:			F CONSTRUCTION D1 - MAIN BUILDING 01	(X3) DAT	F SURVLY MPLETED
		445116	B. WING			10	03/2016
NAME OF	PROVIDLR OR SUPPLIFE		'	51	IRLL LADDRESS, CITY, STATE, ZIP CODE	101	0012010
NHC HE	ALTHCARE, \$MITHVI	LLE			25 FISHER AVE P O BOX 549 MITHVILLE, TN 37166		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DLI-ICIENCII-S Y MUST REPRECEDED BY FULL SCIULINI RIVING INFORMATION)	ID PRLFII) (AG	,	PROVIDER'S PLAN OF CORRECTION (LACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BF	(X5) COMPLETION DATE
K 021	Continued From pa	ge 2	Ко	21			
		vertical openings are of an appropriate fire protection	 				
	cquipment rooms d This STANDARD is	er rooms, and mechanical oors are kept closed. s not met as evidenced by: jons, the facility failed to corridor fire doors.					
	The finding inlouded	d:					
	penetrations (holes the cross corridor fi following locations: a. ICF fire doors (2 b. Reflections fire d 4.6.2.1 (2000 Editio	3/16 at 8:48 AM, revealed from removed hardware) on re doors (1 1/2 hr rated) in the of 2) oors (2 of 2). NFPA 101, n), NFPA 101, 8.2.3.2.1 A 80, 15-2.5.4 (1999 Edition)					
	deficiencios were id	vas present when the entified and acknowledged by tring the exit conference on					
K 029 SS≔F	NFPA 101 LIFE SAME One hour fire rated fire-rated doors) or a extinguishing system and/or 19.3.5.4 protothe approved automoption is used, the author spaces by smidoors. Doors are safield-applied protect	construction (with a hour an approved automatic fire in accordance with 8.4.1 ects hazardous areas. When latic fire extinguishing system areas are separated from oke resisting partitions and elf-closing and non-rated or ive plates that do not exceed pottom of the door are	K 02	29			

PRINTED: 10/11/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARL & MEDICAID SERVICES OMB NO. 0938 0391 STATEMENT OF DEFICIENCIES (X1) PROVIDENSUPPLIERCHA (X2) MULTIPLE CONSTRUCTION (X3) DATE SHRVLY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLLIED A. BUILDING 01 - MAIN BUILDING 01 B. WING _______ 445116 10/03/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRUSS, CHY, STATE, ZIP CODE 825 FISHER AVE P O BOX 549 NHC HEALTHCARE, SMITHVILLE SMITHVII.LE, TN 37166 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D (X5) COMPLETION DATE (FACITULIFICIENCY MUST BE PRECLUED BY HITH PRI.TIX PRECIX (FACH CORRECTIVE ACTION SHOULD BE REQUEATORY OR USC (DENTIFYING INFORMATION) TAG MG CROSS RULFRENCLD TO THE APPROPRIATE DEFICIENCY) K 029 Continued From page 3 K 029 K029-Maintenance Supervisor, in consolitation with a 11/15/2016 permitted. 19.3.2.1 3M supervisor and Pirestop Technologies, will repair This STANDARD is not met as evidenced by: the penetrations and seal the seam in the back parking Based on observations, the facility failed to lot boiler from and repair the penetrations in the ICF boiler room by 13/15/16 maintain the hazardous areas. Maintenance Supervisor, along with the 3M The findings infooded: sopervisor, reviewed other hazardous areas of the center (boiler rooms and mechanical rooms) for 1. Observation on 10/3/16 at 10:12 AM, revealed penetrations on 10/18/16. All areas in compliance. a three (3) inch penetration sprinkler pipe (masonry wall) in the back parking fol boiler room. Maintenance Supervisor will conduct a Quality Assorance Study (QA) on penetrations in Ingardous 2. Observation on 10/3/16 at 10:13 AM, revealed areas (butter mous and mechanical moms). QA with seam on the back wall joining the side walt was be conducted weekly for 3 weeks or until substantial not sealed from the floor to deck (masonry wall). compliance. Findings will be reported to the QA in the back parking lot boiler room. Committee on 11/10/16 QA Committee consists of Medical Director, Administrator, Director of Nursing. 3. Observation on 10/3/16 at 12:59 PM, revealed Health Information Manager, Social Services multiple penetrations in the masonry wall of the Director, Assistant Director of Nursing, and Director of Robati ICF boiler room consisting of metal conduit. wires, improper fire stop, and holes, NFPA 101. 19.3.2.1 (2000 Edition) Maintenance stall was present when the deficiencies were identified, and acknowledged by the administrator during the exit conference on 10/3/16. K 052 NEPA 101 LIFE SAFETY CODE STANDARD K 052 SS-:D A fire alarm system required for life safety shall be, tested, and maintained in accordance with NEPA 70 National Electric Code and NEPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observations, the facility failed to

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/11/2016 T ORM APPROVED. OMB NO. 0938-0391

MO PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIFIVE IA IDENTIFICATION NUMBER		E CONSTRUCTION 01 - MAN BUILDING 01		TE SURVITY WITH LITED
		445116	B WING		10	/03/2016
	PROVIDER OR SUPPLIER ALTHCARE, SMITHVI	LLE	B2	IREL LADDRESS, CHY, STATE, ZIP CODE IS FISHER AVE P O BOX 549 MITHVILLE, TN 37166		
(X4) ID PRETIX TAG	(FACH DEFICIENCY	(NEMENT OF DEFICIENCIES 7 MUST III - PRECEDED BY FULL SC IDENTIFYING INI ORMATION)	ID PRITIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD Ri	COMPLETIC DATE
K 052	Continued From pa	==	K 052	K052-Cart was removed by maintenance s on 10/3/16		11/3/201
	cart obstructing a m the kitchen (remove 101, 19.3.4.5.1 (200	d: 3/16 at 10:05 AM, revealed a nanual fire atarm pull station in ed by maintenance). NI-PA 00 Edition), NEPA 101, 9.6.1.7 PA 72, 2-8.2.1 (1999 Edition).		Maintenance Supervisor inspected the areas fire alarm pull stations in 3 other random areas found to be in compliance. Maintenance supervisor will inscrease staff obstructing fire alarm pull stations by 10/26.	eas in the on not ./16	
K 054 SS≃D	Maintenance staff videticiency was identified administrator do 10/3/16 NCPA 101 LIFE SAI All required smoke activating door hold maintained, inspect	vas present when the tified, and acknowledged by uring the exit conference on FETY CODE'S (ANDARD detectors, including those open devices, are approved, ed and tested in accordance	K 054	Maintenance Supervisor will conduct a Qua Assurance Study (QA) on 3 random area; at alarm pull stations for no obstructions, QA suconducted weekly for 3 weeks or until substruction of Findings will be reported to the Committee on 1377/16 QA Committee on SMedical Director, Administrator, Director of Health Information Manager, Social Service Director, Assistant Director of Nursing, and of Rebah.	round fire will be lambal a QA losts of I Nucsing,	
	This STANDARD is	rer's specifications. 9.6:1:3 8 not met as evidenced by: tion, the facility failed to	·	K054-Smoke delector was moved to an area forther away from the HVAC air flow by Simplex Grinnell on 10/14/16.		 11/3/2016
	smoke detector with flow in the corridor r office. NFPA 101, 19	i: 8/16 at 10:20 AM, revealed a in three (3) teet of HVAC air next to the social service 9.3.4.5.1 (2000 Edition), NFPA Edition) NFPA 72, 2-3.5.1	ì	Maintenance supervisor inspected 3 office run smoke detectors in the center to ensure they within 3 feet of an HVAC air flow on 10/4/10 areas in compliance Maintenance Supervisor will conduct a Quality Assurance Study (QA) on 3 random smoke do ensure they are not located within 3 fact of air flow. QA will be conducted weekly for 3 air flow. QA will be conducted weekly for 3 air flow. QA will be conducted weekly for 3 air flow. QA will be conducted weekly for 3 air flow.	tere not All fy Medius HVAC Weeks or	
	Maintenance staff w deficiencies were id by the administrator 10/3/16.	eas present when the entified, and acknowledged during the exit conference on the entified of) K 062	until substantial compliance. Findings will be to the QA Committee on 11/3/16. QA Commi- consists of Medical Director, Administrator. I of Nursing, Health Information Manager, Suc Services Director, Assistant Director of Nursi Director of Rehal.	ittee Orrector ant	
K 062	NFPA 101 LIFE SAF	ETY CODE STANDARD	K 062			

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			ŀ		: 10/11/2016
		& MEDICAID SHRVICES			C		APPROVED . 0938-0391
STATEMENT AND PLAN C	OF DEHICIENCIES OF CORRECTION	(X3) PROVIDE IVSUPPLIENCE A ID NOTIFICATION NUMBER:			F CONSTRUCTION 01 - MAIN FUILDING 01	(X3) DAT	E SURVEY IPLUTED
		445116	U. WING			10/	03/2016
NAME OF E	'ROVIDER OR SUPPLIER			31	TREET ADDRESS, CITY, STATE VICCODE	<u></u>	<u> </u>
NHC HEA	NETHCARE, SMITHVI.	LLE			25 FISHER AVE P O BOX 549 MITHVILLE, TN 37166		
(X4) IO PREFIX FAC	(LACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	II) PRLt-I TAG	x	PROVIDER'S PLAN OF CORRECTION (LACH COPERLOTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDE (CROSS-REFERENCE)	D FIL	COMPLETION DATE
K 062 SS=D	continuously mainta condition and are in periodically 19.7 9.7 5. This STANDARD is Based on observational maintain the sprinkl The findings inlouded. Cobservation on 1 damaged sprinkler and in the ICF activ (2000 Edition) NFPA 13, 12-1 (199 (1999 Edition). 2. Observation on 1 the storage area (be no sprinkler coverage Lidition) NFPA 101, 3. Observation on 1 sprinkler lines supported the miscellaneous locations: a. Long hall by therab. ICF short hall cord. Corridor by ICF at (2000 Edition), NFPA 13, 6-1.1.5* (in Maintenance staff with deficiencies were identically supported the miscellaneous continuous contin	c sprinkler systems are sined in reliable operating aspected and tested .6, 4.6.12, NFPA 13, NFPA 25, as not met as evidenced by: sions, the facility failed to ser system. od: 0/3/16 at 9:03 AM, revealed a in the ICF clean linen room sity room. NFPA 101, 19.3.5.1 A 101, 9.7.11 (2000 Edition) 99 Edition) NFPA 25, 12-1 0/3/16 at 9:25 AM, revealed chind the ICF boiler room) had ge. NFPA 101, 19.3.5.1 (2000 9.7.1.1* (2000 Fdition) 0/3/16 at 12:47 PM, revealed orting HVAC duct work and a pipes in the following capy ridor by 203 ctivities. NFPA 101, 19.3.5.1 A 9.7.1.1* (2000 Edition)	i Ko	062	1) Sprinklers will be replaced in ICF clean and ICF activity room by 11/15/16. 2) Sprinkler coverage will be added to the starea behind the ICF bailer room by 14/15/16. 3) HV/AC dust work and other pipes were state long hall by disrapy, the ICF short hall the corridor by ICF activities on 10/4/16 they were not placing any pressure on sprinking were not placing any pressure on sprinking other sprinklers in content on 10/4/16. All in compliance, Maintenance supervisor observed another sample of other areas of the center on objects were resting on or placing pressur sprinkler lines on 10/4/16. All sprinkler lines supporting other objects. Maintenance supervisor with conduct a Quality Assurance Study (QA) on sprinklers QA will conducted in 10 random sprinklers weekly I weeks or until substantial compliance, in easier not damaged. Findings will be reported to Committee on 11/3/16. QA Committee consistent Director, Administrator, Director of Health Information Manager, Sucial Services Director, Assistant Director of Nursing, and I of Rehab.	forage 6. contest in y 204, it to ensure der lines, unple of sprinklers rved 0 ensure to on s not libe for 3 ure they o the QA ists of Nursing,	11/15/2016

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB_NO: 0938-0391 STATEMENT OF DEPICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRUCTION IDENTIFICATION NUMBER: COMPLETED A BUILDING O1 - MAIN BUILDING O1 445116 B. WING 10/03/2016 NAME OF PROVIDER OR SUPPLIER STRUCT ADDRESS, CITY, STATE, ZIP CODE 825 HISHER AVE P O BOX 549 NHC HEALTHCARE, SMITHVILLE SMITHVILLE, TN 37166 SUMMARY STATEMENT OF DEFICIENCIES PROVIDLISS PLAN OF CORRECTION (X4) (D ίD (X1) COMPLETION PREFIX (CACH DEFICIENCY MUST UIT PRECEDED BY FULL PREFIX (FACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE IAG REGULATORY OR USC IDENTIFYING INFORMATION) IAG DACE DEFICIENCY) K 066 Continued From page 6 K 066 K 066 NFPA 101 LIFE SAFETY CODE STANDARD K 066 K066-Cigarette filters were removed from molel; and 11/3/7016 SS=D trashean and properly disposed of on 10/4/16. Smoking regulations are adopted and include no less than the following provisions: Maintenance supervisor inspected other areas of the center for argarette filters in pmlch or trashcaps on (1) Smoking is prohibited in any room, ward, or 10/4/16 All areas clear of eigerette filters, Facility compartment where flammable liquids. has a designated soutking area and all digarette filters were properly disposed. combustible gases, or oxygen is used or stored and in any other hazardous location, and such Maintenance supervisor will inservice staff on only area is posted with signs that read NO SMOKING smoking in the designated smoking area by or with the international symbol for no smoking. 10/26/16. A no smoking sign will also be placed in the countyard by 10/26/16 (2) Smoking by patients classified as not responsible is prohibited, except when under Maintenance Supervisor will conduct a Quality direct supervision. Assurance Study (QA) on eigarette filters (smoking) in the courtyard area. QA will be conducted weekly (3) Ashtrays of noncombustible material and safe for I weeks or until substantial compliance. Findings design are provided in all areas where smoking is will be reported to the QA Committee on 11/3/16, QA permitted. Committee consists of Medical Director. Administrator, Director of Nursion, Health (4) Metal containers with self-closing cover. Information Manager, Social Services Director, devices into which ashlrays can be emptied are Assistant Director of Nursing, and Director of Robab. readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations, the facility failed to comply with the smoking regulations. The finding intouded: Observation on 10/3/16 at 9:24 AM, revealed. digarette filters disposed on the landscape mulch around the courtyard area. Observation on 10/3/16 at 9:24 AM, revealed cigarette filters in a trash can (combustible) the courtyard area.

DEPARTMENT OF HEALTHAND HUMAN SERVICES CHNTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDENSUPPLIFFICEIA IDI NUI ICATION NUMBER	A BUILDING O	(X3) DATE SURVLY COMPLETED		
<u>. </u>		445116	R WING _		10/0	03/2016
	CROVIDI, RORE SUPPLIER		82	REFT ADDRUSS, CITY, STARL, ZIP CODE 5 FISHER AVE P O BOX 549 AITHVILLE, TN 37166	<u> </u>	<u> </u>
(X4) ID PREFIX TAG	(HACH DEFICIENC	AD MENT OF DEFICIENCIES Y MUST THE PRECEDED BY FULL LSC IDENTIL YING INFORMATION)	ID PRITIX TAG	PROVIDERS PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD CROSS-RELITERINGED TO THE APPROPRIED CROSS-RELITERINGED TO THE APPROPRIED CROSS-RELITERINGED TO THE APPROPRIED CROSS-RELITERINGENCY)) BE	(X5) COMPLETIO DATC
K 066	deficiencies were i	age 7 was present when the dentitied, and acknowledged or during the exit conference on	K 066		, ,	
K 073 \$\$=D	NCPA 101 LIFE SA Combustible decor- unless they are flar quantity that hazar- is not present, 18.7 This STANDARD Based on observa	rations shall be prohibited me-retardant or in such limited d of fire development or spread 7.5.4, 19.7.5.4 is not met as evidenced by: fions, the facility failed to rement of combustible	K 073	K073 All combustible decorations in Rooms 104, 105, 207, ICF Activity Room, and Refl Activity Room, and Refl Activity Room will either be neared with Ni rated fire repartant or removed from the cent 17/1/16 Maintenance supervisor inspected other ranges/100ms of center for combustible decorations in compliance. Maintenance supervisor will inscribe staff of	PA 255 cc by dom	11/3/2016
K 077 \$\$=D	AM, revealed decorotardant in the following the ICF activities area. NFF Maintenance staff of deficiencies were to by the administrato 10/3/16. NFPA 101 LIFE SA Piped in medical gasses on observa	/3/16 at 9:00 AM through 9:30 rations not treated with flame owing locations: 102, 104, 105, ies and the Reflections PA 101, 19.7.5.4 (2000 Edition) was present when the dentified, and acknowledged or during the exit conference on FETY CODE STANDARD as systems comply with NFPA is not met as evidenced by: flons, the facility failed to in medical gas lines.	k 077	combestible decorations by 10/26/16. Maintenance supervisor will conduct a Quality Assumance Study (QA) on combestible decor QA will be conducted on random areas/room center weekly for 3 weeks or until substantia compliance. Findings will be reported to the Committee on 11/3/16. QA Committee considered to the Committee on 11/3/16. QA Committee considered birector, Administrator, Director of Health Information Manager, Social Service; Director, Assistant Director of Nursing, and of Rebab.	ty ations, s in I QA sis of Nucsing,	

DEPAREMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED CENTERS FOR MEDICARE & MLDICAID SERVICES OMB NO. 0938 0391 STATEMENT OF DELICIENCIES (XT) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A Building 01 - MAIN BUILDING 01 445116 6 WING 10/03/2016 NAME OF PROVIDER OR SUPPLIFIX STREET ADDRESS, CHY, STATE, ZIP CODE 825 FISHER AVE P O BOX 549 NHC HEALTHCARE, SMITHVILLE SMITHVILLE, TN 37166 SHMMARY STATEMENT OF DEFICIENCES (FACITUAL HORLY MUST BE PRECIFIED BY FULL PROVIDIR'S PLANOF CORRECTION (X4) ID m CDMPLETKM DATE PRLI-IX (FACH CORRECTIVE ACTION SHOULD BE PRUIX RUCULATORY OR USC IDENTIFYING INFORMATION) TAC TAG CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) K 077 Continued From page 8 K 077 K077-Medical gas lines are abandoned and not in use. 11/1/2016 Observation on 10/3/16 at 12:50 PM, revealed Administrator letter is included at the end of this plan dissimilar metals touching medical gas lines of correction. above the ceiling in the following locations: a. Skilled (long) hall by therapy D. O2 slorage room (12:53 PM) NEPA 101. 19.3.2.4 (2000 Edition) Nt PA 99, 4-3.1.2.9 (1999) Edition) Maintenance stalt was present when the deficiencies were identified, and were acknowledged by the administrator during the exit conference on 10/3/16. K 130 NEPA 101 MISCELLANLOUS K 130 K130--Reflections fire door was reculibrated and 11/10/2016 SS=F harges tightened on 10/17/16. Penetrations were OTHER LSC DEFICIENCY NOT ON 2786 repaired in long hall riser room and fire wall by Room This STANDARD is not met as evidenced by: 214 on 10/17/16. Every opening in a lire barrier shall be protected to limit the spread of fire and restrict the Maintenance supervisor inspected 3 other random fire doors to ensure ease of opening and closing on movement of smoke 10/12/16. All fire doors working properly. from one side of the fire barrier to the other. Tho Maintenance supervisor inspected. 3 other random fire protection areas for penetrations on (0/)?/16. No other rating for opening protectives shall be as follows: penetrations found. (1) 2-hour fire barrier - 11/2-hour fire protection rating Maintenance Supervisor will conduct a Quality (2) 1 hour fire barrier - 1-hour fire protection Assurance Study (QA) on 3 randomly selected fire rating where doors and 3 randomly selected areas for penetrations. used for vertical openings or exit enclosures, or QA will be conducted weekly for 3 weeks or until 3/4-hour substantial compliance. Findings will be reported to fire protection rating where used for other than the QA Committee on 11/10/16, QA Committee vertical consists of Medical Director, Administrator, Director openings or exit enclosures, unless a tesser fire of Nursing, Health Information Manager, Social Services Director, Assistant Director of Natsing, and protection rating is specified by Chapter 7 or Chapters 11 Director of Reliab (hrough 42 NFPA 101, 8.2.3.2.3.1* (2000 Edition) 8.2.3.2.4 Penetrations and Miscellaneous Openings in Fire

PRINTED: 10/11/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDEN/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING 01 - MAIN BUILDING 01 COMPLETED 445116 B. WING 10/03/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 825 FISHER AVE P O BOX 549 NHC HEALTHCARE, SMITHVILLE SMITHVILLE, TN 37166 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION) CI (bX) PROVIDER'S FLAN OF CORRECTION (XS) COMPLETION PRFFIX PREFIX EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-RI-FERENCED TO THE APPROPRIATE DATE DUFICIENCY) K 130 Continued From page 9 K 130 Barriers. 8.2.3.2.4.1* Openings in fire barriers for air-handling ductwork or air movement shall be protected in accordance with 9.2.1. 8.2.3.2.4.2* Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that designed for the specific purpose. (2) Where the penetrating item uses a sloove to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier. and the space between the item and the sleeve meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) *Insulation and coverings for pipes and ducts shall not

conditions is met:

following

pass through the fire barrier unless one of the .

PRINTED: 10/11/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MUSTIPLE CONSTRUCTION (X3) DATIF SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 445116 B. WING 10/03/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRUSS, CITY, STATE, ZIP CODE 825 FISHER AVE P O BOX 549 NHC HEALTHCARE, SMITHVILLE SMITHVILLE, TN 37166 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PRECIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 130 Continued From page 10 K 130 The material shall be capable of maintaining the fire resistance of the fire barrier. b. The material shall be protected by an approved device that is designed for the specific purpose. (4) Where designs take transmission of vibration into consideration. any Vibration isolation shall meet one of the following conditions: a. It shall be made on eithor side of the fire barrier. b. It shall be made by an approved device that is designed for the specific purpose. NFPA 101, 8.2.3.2.4 (2000 Edition) 7.2.1.4.5 The forces required to fully open any door manually in a means of egress shall not exceed 15 lbf (67 N) to release the latch, 30 lbf (133 N) to set the door in motion, and 15 lbf (67 N) to open the door to the minimum required width. Opening forces for interior side-hinged or pivoted-swinging } doors without closers shall not exceed 5 lbf (22 N). These forces shall be applied at the latch stile. NFPA 101, 7.2.1.4.5 (2000 Edition) Based on observations and testing the facility failed to comply with the following NFPA Life Safety Code (2000 Edition) requirements.

FORM CMS-2567(02-99) Previous Versions Obsolete

The findings included:

Event If1; \$(15)321

Facility ID: TN2101

If continuation sheet Page 11 of 12

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		AND HUMAN SERVICES				PRINITLI FORM): 10/11/2016 APPROVED
		& MEDICAID SERVICES				OMB NO	0938-0391
AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIFIZELIA IDENTIFICATION NUMBER:	1 ' '		TIPI E CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DA	TE SURVEY MPLETED
		445116	B. WINC	3	<u> </u>	10	/03/2016
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(X4) ID PREFIX FAG	(FACITIDE ICIENCY	TEMENT OF DEHCILNCILS / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(E) PREF TAG	L	PROVIDER'S PLAN OF CORRECT	LÚ BE	(X5) • COMPLETION DATE
K 130	corridor fire door in 10/3/16 at 11:08 At than 15 lbs of force 19.2.1 (2000 Edition Edition) 2. Observation on 1 fire wall penetration a. I ong half sprinkle conduit Gypsum wab. Fire wall by 214 (conduit masonry wa 4.6.1.2 (2000 Edition) Maintenance staff wideficiencies were id	testing of the Reflection cross the means of egress on M, revealed it required more to fully open. NFPA 101, n) NFPA 101, 7.2.1.4.5 (2000 0/3/16 at 1:4/ PM, revealed s in the following locations: or riser room (1/2 inch metal all) 2 inch hole and 1 inch metal all) 2 inch hole and 1 inch metal all) 3 inch hole and 1 inch metal all) 2 inch hole and 1 inch metal all) 3 inch hole and 1 inch metal all) 4 inch hole and 1 inch metal all) 6 inch hole and 1 inch metal all) 7 inch hole and 1 inch metal all) 8 inch hole and 1 inch metal all) 9 inch hole and 1 inch metal all) 2 inch hole and 1 inch metal all) 3 inch hole and 1 inch metal all) 4 inch metal all) 4 inch metal all) 6 inch metal all) 7 inch metal all) 8 inch hole and 1 inch metal all) 9 inch hole and 1 inch metal all)	K.	730			
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